
OLR Bill Analysis

sHB 5386 (as amended by House "A")*

AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.

SUMMARY:

This bill revises various insurance statutes, as detailed in the section-by-section analysis below. Among other things, it:

1. allows the insurance commissioner to share and receive confidential information with and from the Federal Insurance Office and the Bank for International Settlements;
2. establishes a \$2,500 filing fee for each "Form A" (i.e., application seeking to change control of a domestic insurer); and
3. requires an insurer's or HMO's board of directors to receive and review financial examination reports from the commissioner.

The bill also deletes obsolete provisions and makes technical and conforming changes.

*House Amendment "A" removes provisions that (1) allowed a consumer 30 instead of 10 days to return a replacement life insurance policy to the insurer for cancellation and (2) imputed knowledge of financial examination reports to the board of directors. It also changes the reporting date for certain signed statements from surplus lines brokers from the first to the 15th of certain months.

EFFECTIVE DATE: Upon passage, except as otherwise noted below.

§ 1 – CONFIDENTIAL INFORMATION

The bill allows the insurance commissioner to receive and share confidential information from and with the Federal Insurance Office, which was created under the federal Dodd-Frank Act, and the Bank for

International Settlements, an international organization that fosters international monetary and financial cooperation and serves as a bank for central banks. By law, the commissioner may already receive and share confidential information from and with the National Association of Insurance Commissioners and the International Association of Insurance Supervisors.

§§ 2 & 3 – “FORM A” FILING FEE

The bill establishes a \$2,500 filing fee for each Form A filed with the Insurance Department. Form A is an application for a change of control of a domestic insurer by merger or acquisition.

EFFECTIVE DATE: October 1, 2012

§ 4 – FINANCIAL EXAMINATION REPORTS

By law, the insurance commissioner may conduct financial examinations of insurers, health care centers (i.e., HMOs), and related companies doing business in Connecticut.

The bill requires the commissioner to provide an examination report to the examined entity, along with any recommendations or written statements from the commissioner or examiner. The entity’s board of directors’ secretary must give a report copy or summary to each director and certify to the commissioner in writing that this has occurred.

The bill also requires the chief executive officer of the examined entity, within 90 days of receiving the report or summary, to present it to the board of directors at a regular or special meeting.

EFFECTIVE DATE: October 1, 2012

§§ 5 & 10 – LATE FILING FEE

By law, if an insurer or HMO files a quarterly or annual financial statement with the insurance commissioner past its due date, the commissioner fines the entity \$175 for every day the statement is late. Under current law, if a fraternal benefit society files an annual statement late, it is fined \$100 for every day late. The bill increases the

late filing fee for a fraternal benefit society to \$175 per day late.

The bill allows the insurance commissioner to waive a late filing fee if (1) the entity cannot file the statement because its home state has proclaimed a state of emergency that prevents the entity from filing it or (2) the entity's home state regulatory official has allowed the entity to file it late.

EFFECTIVE DATE: October 1, 2012

§§ 7 & 8 – PREMIUM FINANCE COMPANY LICENSE FEE

The bill increases the insurance premium finance company license and annual renewal fee from \$50 to \$300. Engaging in such business without a license is a class A misdemeanor punishable by up to one year in prison, up to a \$2,000 fine, or both.

EFFECTIVE DATE: October 1, 2012

§ 9 – HMO FINANCIAL EXAMINATION

The bill explicitly allows the insurance commissioner to order HMOs to produce books, records, or other information necessary for the commissioner to examine the entity's financial condition. The HMO must pay for any such examination.

EFFECTIVE DATE: October 1, 2012

§§ 11 & 12 – SURPLUS LINES BROKERS

By law, the insurance commissioner must maintain, publish, and make available to surplus lines brokers a list of insurance lines that are unavailable from licensed insurers.

Under current law, licensed surplus lines brokers and their clients that procure insurance that is not on the insurance commissioner's list must file with the commissioner an affidavit showing they made diligent efforts to obtain the insurance from a licensed insurer. The affidavits are due within 45 days after procuring the insurance.

The bill requires a signed statement instead of an affidavit, eliminating a notary requirement. It requires the licensee to submit the

signed statements to the commissioner electronically on the 15th day of February, May, August, and November in each year.

§ 13 – SURETY BAIL BOND AGENT EXAMINATION ACCOUNT

PA 11-45 created the surety bail bond agent examination account as a separate, nonlapsing account within the Insurance Fund. Under current law, the funds remaining in the account at the end of the fiscal year are transferred to the General Fund. The bill instead transfers the funds at the end of each calendar year.

§ 14 – REPEALER

The bill repeals a provision that prohibited insurers or HMOs from rescinding (i.e., retroactively cancelling) a health insurance policy unless they receive the insurance commissioner’s permission. The repeal removes a conflict with federal and state law. Under federal health care reform provisions and PA 11-58 (§§ 54-66), a rescission is considered an adverse determination, which is subject to the mandated internal and external appeal process.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/15/2012)